STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DAT		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00		COMPLETED	
		155132	B. WING	<del></del>	08/19/2011	
		I		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	8		EADOW DR		
	E REGIONAL REH	ARII ITATION		LLE, IN46122		
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	· ·	ICY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE	
F0000						
				1		
	This visit was fo	r Investigation of	F0000	Submission of this plan of corre	ection	
	Complaint IN00	0094797.		is not a legal admission that a		
				deficiency exists or that this	moatly.	
	Complaint IN00	0094797 - Substantiated.		statement of deficiency was concited, and is also not to be cons	-	
	•	iciencies related to the		as an admission of interest agai	•	
		ited at F281, F333, F514,		the facility, the Administrator of	•	
		nea at 1201, 1333, 1314,		employees, agents, or other		
	and F9999.			individuals who draft or may be	e	
				discussed in this response and p		
	Survey dates: August 18 and 19, 2011			correction. In addition, prepara		
				of this plan of correction does r	not	
	Facility number:	000057		constitute an admission or agre	ement	
	Provider number			of any kind by the facility of th	e truth	
	AIM number:	100266570		of any facts alleged or see the		
	rinvi numoci.	100200270		correctness of any allegation by	the	
	G , 37	1 DI 1 DVI		survey agency.		
	Survey team: va	anda Phelps, RN		The facility is respectfully requ	esting	
				a desk review.		
	Census bed type	:				
	11 SNF					
	76 SNF/NF					
	87 Total					
	Census payor typ	ne:				
		ρε.				
	15 Medicare					
	58 Medicaid					
	14 Other					
	87 Total					
	Sample: 3					
	These deficienci	es also reflect state				
	_	accordance with 410 IAC				
	16.2.					
LABORATOR	Y DIRECTOR'S OR PROV	/IDER/SUPPLIER REPRESENTATIVE'S SIO	GNATURE	TITLE	(X6) DATE	

(X6) DATE

Any defiencystatement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

LCZV11

Facility ID:

000057

If continuation sheet

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO	ONSTRUCTION  00	(X3) DATE SURVEY COMPLETED	
	155132	A. BUILDING B. WING		08/19/2011	
NAME OF PROVIDER OR SUPPL		STREET A	ADDRESS, CITY, STATE, ZIP CODE EADOW DR LLE, IN46122		
PREFIX (EACH DEFICE	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PERCEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
Quality review co Bartelt, RN.	ompleted 8/24/11 by Jennie				
facility must me quality.  Based on record the facility fail followed the fadministration to 1 of 3 reside reviewed for m.  F)  Findings inclust the closed clin was reviewed. The record indiand oriented at recuperate from diagnoses inclusto, history of states. This record did diabetes, or photoher diabetic monitoring. No entries on 7/30 3:30 p.m., and blood sugar m. resident was "states".	ovided or arranged by the et professional standards of and review and interviews, ed to ensure the nurse ve rights of medication while administering insuling that in the sample of 3 medication errors. (Resident de:  mical record of Resident Fron 8/18/11 at 1:12 p.m. icated the resident was alerted had been admitted to make surgery. Her uded, but were not limited seizure disorder.  If not include a diagnosis of system orders for insulin or medications or glucose fursing notes indicated and at 12:30 p.m. and at 12:30 p.m. and at 12:30 p.m. and at 13:31/11 at 1:00 a.m. for conitoring and notations the asymptomatic" and/or signs or symptoms of	F0281	Corrective actions: The nurse was educated/counseled as result of the medication error the DON. Resident vital sign were monitored and facility protocol was followed per medication error policy and procedure. The reident did in have a negative outcome. Or residents having the potential be affected: No other reside were affected by the deficient practice. In the event a medication error isidentified facility policy and procedure be followed. Systematic char An in-service will be compleregarding medication administratrion/rights of medication and pre-setting medication for all licensed nurses. Medication errors we followed up by the DON and brought to daily clinical review (DCR) (5 days/week except holidays and weekends) for review upon each occurrence an ongoing basis. MAR/TAF audits will be completed by the unit manager(s) or designed weekly x 4 weeks, then mon 2. Addendum per 9-7-11 ISD request: If a resident photo cannot be placed on the MA	a r by sis solution of the result of the res	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		155132	B. WIN			08/19/20	011
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER	L Company of the Comp			ADOW DR		
DANVILL	E REGIONAL REH	ABILITATION		1	LE, IN46122		
(X4) ID				ID	,		(X5)
PREFIX	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL			PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE			COMPLETION
TAG	· ·	LSC IDENTIFYING INFORMATION)		TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		E	DATE
	hyper or hypogly	· · · · · · · · · · · · · · · · · · ·	1		upon admission, a resident II	5	
	hyper or hypogry	vecima.			bracelet will be placed on the		
					resident until a picture can be	e	
		or and the Corporate			placed on the MAR. Nurses		
		t were interviewed on			utilize the 5 rights of mdication	n	
	•	.m. regarding these			pass to assist in ensuring medications are being provid	ed to	
		Iministrator indicated			the correct resident(s). Medi		
		eceived an injection of			Records or the Unit Manager		
		for another resident, but			audit MAR's within 72 hours		
	had not suffered	any ill effects.			admission to ensure pictures		
					in placeMonitoring: Medicati errors will be monitored per f		
	Interview with R	esident F on 8/18/11 at			policy and procedure and tak	, ,	
	6:26 p.m. indicat	ted she had received an			through DCR and reviewed b		
	injection of insul	in which was intended			IDT upon each occurrence of	n an	
	for the resident a	cross the hall. She			ongoing basis. Medication e		
	indicated she had	d not met the nurse who			will be brought to monthly QA	A on	
		medication before,			an ongoing basis.Date of completion: 9-16-11		
		admitted the previous			Completion: 9-10-11		
		dicated the nurse came in					
	-	, which she accepted					
	_	receiving injections of					
	another medicati						
		the nurse returned right					
	-	ond injection, she began					
		ause she knew she was					
		jections at the same time.					
	-	ctions and questions, the					
	-	e medication and then					
	told her it was Lo	ovenox [for blood clot					
	prevention], her	usual medication.					
	When she asked	the nurse what was in the					
	first injection, sh	e was told it was insulin,					
	-	en they both realized the					
	mistake.	<b>,</b>					

PRINTED: 09/15/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED	
		155132	B. WIN			08/19/2011	
NAME OF I	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE	!	
NAME OF I	KOVIDEK OK SOLI EIEK			1	ADOW DR		
DANVILL	E REGIONAL REH	ABILITATION		DANVIL	_LE, IN46122		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)		
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)	DATE	
	Interview with LPN #1 was conducted on						
	_	.m. She indicated she					
		ident F with another					
		, 20 units of Novalog					
	I -	ke on Saturday July 31,					
	· ·	:00 and 8:00 a.m. In					
		f, she indicated both					
		en admitted the previous					
		was her first contact with					
		She said she called					
	Resident F by the other resident's name as						
		oom and Resident F had					
		: She indicated arm					
		graphs are not used on					
	· ·	residents' names are					
	posted by the do	ors. She indicated she					
	had Resident F's	oral medications with					
	her, and the other	r resident's insulin					
	instead of Reside	ent F's Lovenox.					
	Review of the M	edication Error Report on					
		o.m. indicated a dose of					
	_	malog 75/25 (sic)" was					
		t F on 7/30/11 at 8:00					
	~						
	1 ^	indicated the insulin was					
	given to the wron	ng resident.					
	Page 171 of the G	Geriatric Medication					
	"	th edition, indicated					
	under "Steps of M						
	Administration"						
		ghts included: "accurate					
		nistration (i.e., right					
		nt, right dose, and					
		,, 4114			ļ	I	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE C	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED	
		155132	A. BUILDING B. WING		08/19/2011
	PROVIDER OR SUPPLIER LE REGIONAL REHA		STREET 255 M	ADDRESS, CITY, STATE, ZIP CODE EADOW DR ILLE, IN46122	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PERCEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
	dosage form, right time)"  The personnel file of LPN #1 was reviewed on 8/19/11 at 2:30 p.m. The file indicated LPN #1's employment was terminated on 8/1/11 for "serious medication error that could have resulted in harm to resident," and failure to follow the five rights of medication administration.  This federal tag relates to Complaint IN00094797.  3.1-35(g)(1)				
F0333 SS=D	free of any signific Based on record the facility failed residents sampled the total sample of significant medic received insuling for her. (Resident	of 3 was free of sation error, in that she which was not ordered t F)	F0333	Corrective actions: The nurs was educated/counseled as result of the medication error the DON. Resident vital sign were monitored and facility protocol was followed per medication error policy and procedure. The Resdient did have a negative outcome Ott residents having the potentia be affected: No other reside were affected by the deficien practice. In the event a medication error is identified	not ner all to nts t

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		155132	A. BUII B. WIN			08/19/2	011
		<u> </u>	B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF	PROVIDER OR SUPPLIE	R			ADOW DR		
DANVII I	LE REGIONAL REH	IABII ITATION		1	LE, IN46122		
(X4) ID	1	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	1	NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION DATE
IAG	<del> </del>	n 8/18/11 at 1:12 p.m.	+	IAG	facility policy and procedure	will	DAIL
		•			be followed.Systematic char		
		eated the resident was alert			An in-service will be comple	•	
	1	I had been admitted to			regarding medication		
	_	knee surgery. Her			administratrion/rights of		
	_	led, but were not limited			medication pass and pre-se injections for all licensed nu		
	to, history of sei	zure disorder.			Medication errors will be foll		
					up by the DON and brought		
	The record did r	not indicate a diagnosis of			daily clinical review (DCR) f		
	diabetes, or phys	sician orders for insulin or			review upon each		
	other diabetic m	edications or glucose			occurrence.Monitoring:		
	monitoring. The	e nursing notes indicated			Medication errors will be monitored per facility policy a	and	
	entries on 7/30/1	11 at 12:30 p.m. and at			procedure and taken throug		
	3:30 p.m., and o	n 7/31/11 at 1:00 a.m.			DCR and reviewed by IDT u		
	documenting blo	ood sugar monitoring and			each occurrence on an ongo		
	1	ident was "asymptomatic"			basis. Medication errors wil		
	1	ere no signs or symptoms			brought to monthly QA on a ongoing basis.Date of	n	
		or hypoglycemia [low			completion: 9-16-11		
	blood sugar]."	or hypogrycenna flow					
	biood sugaij.						
	The Administrat	can and the Components					
		or and the Corporate					
	1	nt were interviewed on					
	1	o.m. regarding these					
		ministrator indicated					
		received an injection of					
		for another resident, but					
	had not suffered	any ill effects.					
	Interview with F	Resident F on 8/18/11 at					
	6:26 p.m. indica	ted she had received an					
	injection of insu	lin which was intended					
	for the resident a	across the hall. She					
	indicated she ha	d not met the nurse who					
	administered the	e injection before, having					
	1	ed the previous evening.					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155132		(X2) MULTIPLE CO A. BUILDING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 08/19/2011	
		100102	B. WING		06/19/2011
NAME OF I	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE	
   DANVILL	E REGIONAL REH	ABILITATION	l l	EADOW DR LLE, IN46122	
(X4) ID	_	TATEMENT OF DEFICIENCIES	I ID	,	(X5)
PREFIX		CY MUST BE PERCEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	DATE
	She indicated the	nurse came in with an			
	injection, which	she accepted because she			
	was receiving inj	ections of another			
	medication twice	daily. However, when			
	the nurse returne	d right away with a			
	second injection,	she began questioning,			
		v she was not to get two			
	l -	same time. Despite her			
	1 "	estions, the nurse			
	1 "	cation and then told her			
	it was Lovenox [				
	_	usual medication.			
		the nurse what was in the			
	· ·	e was told it was insulin			
		en they both realized the			
		icated she had been very			
		would cause her to have			
		id she became very			
	anxious and was	"crying uncontrollably."			
	T., 4				
		e attending physician on			
	8/18/11 at 4:24 p				
		arse calling him to report alled giving her a verbal			
		the blood sugars and the			
		condition every two			
		ight hours. He added he			
	tried to calm the				
		a nondiabetic receives			
	insulin, it is usua				
	· ·	on's own body would just			
	_	wn insulin, until the			
	1 -	ection had worn off, but,			
	nonetheless, it w				
				l .	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE : COMPL		
AND PLAN	OF CORRECTION	155132	A. BUI		00	08/19/2	
		100102	B. WIN		DDDEGG CITY CTATE ZID CODE	00/13/2	011
NAME OF I	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE  ADOW DR		
DANVILL	E REGIONAL REH	ABILITATION		1	LE, IN46122		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	· `	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	·	physician's verbal order					
		in the nursing notes or					
	1	ler section, nor was the led recorded in the					
	record.	led recorded in the					
	record.						
	Interview with L	PN #1 was conducted on					
		.m. She indicated she					
	_	ident F with another					
	1 "	, 20 units of Novalog					
	70/30, by mistak	te on Saturday July 31,					
	2011, between 7:	00 and 8:00 a.m. She					
	indicated the Dir	ector of Nursing had					
	instructed her to	monitor the resident's					
	blood sugar ever	y one hour all day, which					
	she did. In defer	nse of herself, she					
	indicated both re	sidents had been					
	1	vious evening and this					
		tact with either of them.					
		ed Resident F by the					
		ame as she entered the					
	1	ent F had not corrected					
	her.						
	Review of the M	edication Error Report on					
		.m. indicated a dose of					
	_	nalog 75/25 (sic)" was					
		t F on 7/30/11 at 8:00					
	l ~	indicated the medication					
	_	wrong resident. On this					
	1	s's order was documented					
		agar at 11:00 a.m., give					
		snacks accordingly.					
	There were no pl	nysician orders within the					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO	NSTRUCTION 00	(X3) DATE SURVEY COMPLETED	
		155132	A. BUILDING B. WING		08/19/2011
NAME OF F	PROVIDER OR SUPPLIER		STREET A	ADDRESS, CITY, STATE, ZIP CODE	
DANVILL	E REGIONAL REH	ABILITATION	I	ADOW DR .LE, IN46122	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
	this or anything a sugars at all.	Resident F regarding about checking blood relates to Complaint			
F0514 SS=D	each resident in according professional stand complete; accurate accessible; and sy.  The clinical record information to identhe resident's asseand services provipreadmission screes tate; and progress Based on record the facility failed record was compregarding a mediansulin to the wrong professional standard professional standa	review and interviews, to ensure the medical dete. Critical charting cation error of giving	F0514	Corrective actions: no negat outcome occurred with identi resident. Medication error was reported to the physician and DON. Orders received to more resident. Medication error rewas completed per policy an	fied as I Onitor Poort

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155132 08/19/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 255 MEADOW DR DANVILLE REGIONAL REHABILITATION DANVILLE, IN46122 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE omitted from the medical record per procedureOther residents having potential to be affected: in order corporate policy. This impacted 1 of 3 to identify other residents at risk residents reviewed related to medication an audit will be completed to errors in a sample of 3. (Resident F) compare physician orders and MAR's to ensure that they match. No other residents were identified Findings include: as being at riskSystematic changes: In-service education The closed clinical record of Resident F will be completed for licensed was reviewed on 8/18/11 at 1:12 p.m. nurses on the rights of medication and not pre-setting medications. The record indicated this resident was Weekly random audits x 4 weeks. alert and oriented and had been admitted then monthly random audits x 2 to recuperate from knee surgery. Her months will be completed by diagnoses included, but were not limited DON/Unit Manager's to review medication pass and to, history of seizure disorder. lovenox/insulin injections to ensure following policy and The record did not indicate a diagnosis of procedureMonitoring: Findings of the random audits will be brought diabetes, or physician orders for insulin or to monthly QA for 6 months to other diabetic medications or glucose ensure compliance. Date of monitoring. The nursing notes indicated completion: 9-16-11 entries on 7/30/11 at 12:30 p.m. and at 3:30 p.m., and on 7/31/11 at 1:00 a.m. documenting blood sugar monitoring and notations the resident was "asymptomatic" and/or "there were no signs or symptoms of hyper [high] or hypoglycemia [low blood sugar]." The social service progress notes indicated the Administrator had spoken with Resident F on 8/1/11 regarding her complaints "related to the med error that occurred." The Administrator and the Corporate Nurse Consultant were interviewed on 8/18/11 at 3:45 p.m. The Administrator

Facility ID:

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	OF OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155132	(X2) M A. BUII B. WIN	LDING	NSTRUCTION  00	(X3) DATE COMPI 08/19/2	LETED
	PROVIDER OR SUPPLIER			255 ME	ADDRESS, CITY, STATE, ZIP CODE ADOW DR .LE, IN46122	•	
				L			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ATE	(X5) COMPLETION DATE
	indicated Reside	ent F had been unhappy,					
		I not go out to get her					
		when she asked for it.					
		cifically about the					
	_	referenced in the entry,					
		or indicated Resident F					
		injection of insulin					
		ther resident, but had not					
		effects. She and the					
		Consultant both					
		corporate policy to record					
	all the specifics of any medication error						
		orm titled, "Medication					
		d give the report to the					
	1 ^	ing for further action.					
		the medication error were					
	_	d in the resident's medical					
	_	dication Error Report					
	would eventually	y be connected to the					
	nurse's personne	l file, but would not					
	become part of t	he resident's record.					
	Interview with the	ne Director of Nursing on					
	8/18/11 at 4 p.m	. indicated when LPN #1					
	called to report t	he error to her, she					
	instructed the nu	rse to file a Medication					
	Error Report and	l put it under her door.					
	The Director of	Nursing indicated all the					
	details are to be	put onto the form and not					
	in the nursing no	otes. She indicated this					
	was not a proble	m "because the resident					
	had no ill effects	s." She also indicated this					
	was corporate po	olicy.					
	Interview with R	Resident F on 8/18/11 at					

Facility ID:

	OF CORRECTION	IDENTIFICATION NUMBER:	(X2) M	ULTIPLE CO.	NSTRUCTION 00	r ′	E SURVEY PLETED
ANDILAN	or condition	155132	1	LDING		- 08/19/	
		100102	B. WIN				2011
NAME OF I	PROVIDER OR SUPPLIER			1	DDRESS, CITY, STATE, ZIP COI ADOW DR	DE	
DANVILL	E REGIONAL REH	ABILITATION		1	LE, IN46122		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRE	ECTION	(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE API	ULD BE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
	1 ^	ted she had received an					
		in which was intended					
		cross the hall. She					
		d not met the nurse who					
		medication before,					
	1	admitted the previous					
	~	dicated the nurse came in					
	with an injection	, which she accepted					
	because she was	receiving injections of					
	another medicati	on twice daily. However,					
	when the nurse r	eturned right away with a					
	second injection,	she began questioning					
	because she knew	w she was not to get two					
	injections at the	same time. Despite her					
	objections and q	uestions, the nurse					
	injected the med	ication and then told her					
	it was Lovenox [	for blood clot					
	prevention], her	usual medication. When					
	she asked the nu	rse what was in the first					
	injection, she wa	s told it was insulin and					
	that was when th	ey both realized the					
	mistake. She inc	licated she had been					
	afraid the insulin	would cause her to have					
	a seizure. She sa	nid she became very					
	anxious and was	"crying uncontrollably."					
	Interview with th	ne attending physician on					
	8/18/11 at 4:24 p	.m. indicated he					
	remembered a nu	arse calling him to report					
	the error. He rec	called giving her a verbal					
	order to monitor	the blood sugars and the					
	resident's overall	condition every two					
	hours for six to e	eight hours. He added he					
	tried to calm the	_					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) M	I			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00			COMPLETED	
		155132	B. WIN			08/19/2	011
					ADDRESS, CITY, STATE, ZIP CODE	l	
NAME OF	PROVIDER OR SUPPLIEI	· ·		255 ME	ADOW DR		
DANVILLE REGIONAL REHABILITATION					LE, IN46122		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION DATE
IAG	<del> </del>	· · · · · · · · · · · · · · · · · · ·	-	TAG	Benedikery		DATE
		a nondiabetic receives					
		ally not a problem					
	1	on's own body would just					
	_	own insulin until the					
	1	ection had worn off, but					
	nonetheless, it w						
		e physician's verbal order					
		d in the nursing notes or					
	1 * *	der section, nor was the					
		fied recorded in the					
	record.						
	1	LPN #1 was conducted on					
	1	o.m. She indicated she had					
	1 *	t F with her neighbor's					
	insulin, 20 units	of Novalog 70/30, by					
	mistake, on Satu	ırday July 31, 2011,					
	between 7:00 an	d 8:00 a.m. She					
	indicated she im	mediately called the					
	physician who h	ad calmed her fears					
	somewhat when	he explained a negative					
	effect on a nond	iabetic would probably					
	not occur. How	ever, she'd still been very					
	upset and also ca	alled her Director of					
	Nursing. She wa	as instructed to file a					
	Medication Erro	r Report form and put it					
	under the Direct	or's door, which she did.					
	1	e Director of Nursing had					
		monitor the resident's					
	blood sugar ever	ry one hour all day, which					
	1	dicated she'd documented					
	exactly as direct						
	Review of the M	Iedication Error Report on					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE SURVEY COMPLETED	
		155132	A. BUIL		00	08/19/2	
			B. WING		ADDRESS, CITY, STATE, ZIP CODE		-
NAME OF PROVIDER OR SUPPLIER					ADOW DR		
DANVILLE REGIONAL REHABILITATION			DANVILLE, IN46122				
(X4) ID		TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE			(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
IAG	<u> </u>	.m., indicated a dose of		IAG	,		DAIL
		alog 75/25 (sic) was					
		t F on 7/30/11 at 8:00					
	l -	indicated the medication					
	_	wrong resident. On this					
	_	's order was documented					
	1	od sugar at 11:00 a.m.					
	1	e juice and snacks					
		is order had not been					
	recorded in the n	nedical record.					
	Review of the Medication Error policy						
	and procedure pr	esented for review on					
	_	.m. by the Corporate					
	Nurse Consultan	t, indicated it instructed					
	staff in the follow	•					
	"page 2: Procedu						
	I -	lent before medication is					
	administered 7. Administer medications only to the residents for whom they are ordered 11. Complete the <i>Medication Error Report</i> on all residents who are involved in a medication error 16. Place the <i>Medication Error Report</i> in a designated administrative file.						
	_	ace the Medication Error					
	Report in the me						
	Report in the me	aicai 1001a.					
	This federal tag r	relates to Complaint					
	IN00094797.						
	3.1-25(b)(9)						
	3.1-50(a)(1)						

STATEMENT OF DEFICIENCIES		· '		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
		IDENTIFICATION NUMBER:	A. BUILDING 00		00	COMPLETED		
	155132		B. WING 08/19/2011				011	
NAME OF P	ROVIDER OR SUPPLIER		•	STREET A	ADDRESS, CITY, STATE, ZIP CODE	•		
				l	ADOW DR			
DANVILL	E REGIONAL REH	ABILITATION		DANVII	LLE, IN46122			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION	PROVIDER'S PLAN OF CORRECTION		
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL	PREFIX		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION	
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)		<u> </u>	TAG DEFICIENCY)			DATE	
	3.1-50(a)(2)							
F9999			1					
17777								
	STATE FINDIN	CS	FO	999	Corrective action: an incider	nt	09/16/2011	
	STATE TINDIN	G5	17	,,,	report on state form 6-04 has		07/10/2011	
					been sent to ISDH regarding			
	3.1-13 ADMINIS	STRATION			identified event. No negative			
					outcome occurred for identifi			
	The administrato	r is responsible for the			resident.Other residents hav			
		nent of the facility, but			the potential to be affected:			
	_	n as a departmental			other residents were affected	•		
		•			the alleged deficient practice			
		xample, director of			Medication error(s) will be			
	_	ervice supervisor, during			reviewed by Admn, DON an			
	the same hours.	The responsibilities of			Regional Direction of Clinica Services (RDCS) to see if sp			
	the administrator	shall include, but are not			monitoring is required that w			
	limited to the foll	lowing:			result in reporting to	""		
		informing the division			ISDH.Systematic changes: /	AII I		
		lowed by written notice			medication errors will be repo			
		•			to RDCS and by the DON or			
	_	ur (24) hours, of unusual			designee and reviewed for			
		directly threaten the			potential reporting to ISDH.			
	welfare, safety, o	or health of the resident or			Other incidents in accordance			
	residents.				with state reporting guideline			
					be brought to the attention of			
	This rule was not	t met as evidenced by:			Regional Director of Operation			
	This full was hot	i met as evidenced by.			(RDO) by the Administrator upon each occurrence for review and			
	<b>.</b>				oversight. Unusual occurren			
		review and interviews,			will be reported immediately			
	the facility failed	to notify the State			the Administrator. All accide			
	Department of H	ealth of an unusual			and incidents will be reviewe			

		X1) PROVIDER/SUPPLIER/CLIA			(X3) DATE SURVEY COMPLETED		
		IDENTIFICATION NUMBER: 155132	A. BUI	LDING	00	08/19/2011	
155152			B. WIN			06/19/2011	
NAME OF PROVIDER OR SUPPLIER				1	ADDRESS, CITY, STATE, ZIP CODE		
DANVILLE REGIONAL REHABILITATION			255 MEADOW DR DANVILLE, IN46122				
		_					
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES  CY MUST BE PERCEDED BY FULL	ID PREFIX		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION	
TAG	`	LSC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE	
	occurrence havin	g the potential of great			days/week (excluding holidays	ys	
		ent. This was related to		and weekends) by IDT, DON & Admn. Monitring: ISDH reportables will be brought		1 &	
	giving insulin to	the wrong resident and					
		residents sampled for			through DCR daily/5 days/w	eek	
	medication errors in a total sample of 3 residents. (Resident F)			(excluding holidays and			
					weekends) to ensure		
		,			investigation and final dispos has been completed per	sition	
	Findings include	:			regulation. DON and Administrator will monitor int	ernal	
	The closed clinic	al record of Resident F			process upon each occurren	ce	
	was reviewed on 8/18/11 at 1:12 p.m.  The record indicated this resident was alert and oriented and had been admitted to recuperate from knee surgery. Her diagnoses did not include diabetes.				and bring forward to monthly	' QA	
					for review on an ongoing basis.Date of completion:		
					9-16-11		
	Although there w	vas not a diagnosis of					
		physician orders for					
		liabetic medications nor					
	glucose monitori	ng. The nursing note					
	review indicated	entries on 7/30/11 at					
	12:30 p.m. and at 3:30 p.m.and on 7/31/11						
	at 1 a.m. docume						
	monitoring and notations the resident was "asymptomatic" and/or "there were no signs or symptoms of hyper or						
	hypoglycemia."	. =					
	The Administrate	or and the Corporate					
	Nurse Consultant	t were interviewed on					
	8/18/11 at 3:45 p	.m. The Administrator					
	indicated Resider	nt F had received an					
	injection of insul	in intended for another					
	resident, but had	not suffered any ill					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155132		(X2) MULTIPLE CC  A. BUILDING  B. WING	00	` '	E SURVEY PLETED 2011	
NAME OF PROVIDER OR SUPPLIER  DANVILLE REGIONAL REHABILITATION			255 ME	ADDRESS, CITY, STATE, ZIP CO EADOW DR LLE, IN46122	DDE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SE CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
	effects.  Interview with R:26 p.m. indicate injection of insulfor the resident a indicated she had before, having juprevious evening nurse came in wishe accepted becompletions of ano daily. However right away with a began questioning was not to get two time. Despite he questions, the numedication and to Lovenox, her uses she asked the numinjection, she was that was when the mistake.  Interview with L 8/18/11 at 7:16 pup had injected Reseneighbor's insulity 70/30, by mistal 2011 between 7 asked immediately also called her D	esident F on 8/18/11 at 6 d she had received an in which was intended cross the hall. She I not met this nurse last been admitted the set. She indicated the than injection, which ause she was receiving ther medication twice when the nurse returned a second injection, she g because she knew she ro injections at the same ter objections and rese injected the hen told her it was ual medication. When rese what was in the first s told it was insulin and the ey both realized the  PN #1 was conducted on .m. She indicated she				

Facility ID:

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA  AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155132		(X2) MULTIPLE CO  A. BUILDING  B. WING	00	r 1	E SURVEY PLETED 2011		
NAME OF PROVIDER OR SUPPLIER  DANVILLE REGIONAL REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE  255 MEADOW DR  DANVILLE, IN46122				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
		which she did. She ployment was terminated					
	not been reported	or indicated the error had d to the Indiana State lealth, because "it doesn't					
	This state finding IN00094797.	g relates to Complaint					
	3.1-13(g)(1)						